**Kentucky Crime Victims Compensation Board**
130 Brighton Park Blvd., Frankfort, KY 40601

# SAFE EXAM / TREATMENT BILLING FORM

Patient Name: _____

***Patient Account #:*** _____

To be entered by CVCB

CVCB case #_____

**Fax completed forms and <u>itemized bills</u> to (502) 573-4817** For information, call: (502) 573-2290 / (800) 469-2120.

## FACILITY INFORMATION

Facility Name:_____ Federal ID#: _____

Address: _____ Phone: _____

_____ Contact: _____

City State Zip

## PATIENT INFORMATION

_____ Female_____ Male_____

Name: First Middle Last

Social Security #: _____ Date of Birth: _____

Insurance _____ Medicaid _____ Date of Examination:_____ Time: _____ a.m. _____ p.m._____

## ASSAULT INFORMATION

Date of Assault:_____ Time: _____ a.m. _____ p.m._____

_____ _____ _____

County City State

## MEDICAL CERTIFICATION

Failure of the examiner to certify that a forensic sexual assault examination, as set forth in 502 KAR 12:010, was performed will result in the denial of your claim.

I hereby certify that a forensic sexual assault examination, as set forth in 502 KAR 12:010, was performed by me upon the above-named patient on:

_____20_____

_____ _____

*Physician, SANE, physician's assistant or advanced practice registered nurse whose training and/or scope of practice includes performance of genital examinations*
(print name)

*License Number*

_____

*Signature*

**Fax or mail completed form with itemized bill to:**
**SAFE Exam Program**
**c/o Crime Victims Compensation Board**
**130 Brighton Park Blvd.**
**Frankfort, KY 40601**
**Fax: 502.573.4817**

**KRS 346.200(9) No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist or health department, the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.**

I authorize the release of this information to KY Crime Victim Compensation Board for billing purposes.

_____ _____

Patient Signature Date